Office of Health Facility Licensure & Certification

OPIOID TREATMENT PROGRAM INITIAL MORTALITY REPORT

FAX THIS REPORT AND RETURN ORIGINAL TO:

Office of Health Facility Licensure & Certification
Attention: Behavioral Health Program
408 Leon Sullivan Way
Charleston, WV 25301-1713
P: (304) 558-0050
F: (304) 558-2515

LOG NUMBER _____

DATE _____

OFFICIAL USE ONLY

NOTE: This form must be submitted within 24 hours of notification of consumer death. An internal investigation must be conducted and submitted to OHFLAC within 14 days. If an ICF/IID client, an internal investigation is to be conducted and submitted to the facility's administrator within 5 days.

CONTACT INFORMATION

Facility Name: _____ **Phone:** ( )

Reported By: _____

Last *First* *M.I.*

CONSUMER INFORMATION

Full Name: _____

Last *First* *M.I.*

Date of Birth: _____ **County of Residence:** _____ **Sex:** ☐ Male ☐ Female

CONSUMER TREATMENT

Admission Date: _____ **Take-home Privileges?** ☐ Yes ☐ No

Dosage of Methadone prescribed at time of death: _____

Date last dosage administered: _____ **Number of take-homes, if applicable:** _____

Psychiatric/medical diagnoses within the last year, if available: _____

All known medications prescribed: _____

Date(s) of any illicit drug screens since admission: _____

EVENT DETAILS

Was death reported to medical examiner? ☐ Yes ☐ No

Date of Death: _____ **Time of death:** _____ ☐ A.M. ☐ P.M.

How did the program become aware of the patient's death: _____

Brief description of events, if known: _____

SIGNATURE

I certify that this report and the information I have provided is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____